MAINE CRIME VICTIMS' COMPENSATION APPLICATION INSTRUCTIONS

These are instructions and examples to help you complete your Victims' Compensation application fully and correctly. The examples in the instructions have the same layout and appearance as the sections of the actual application.

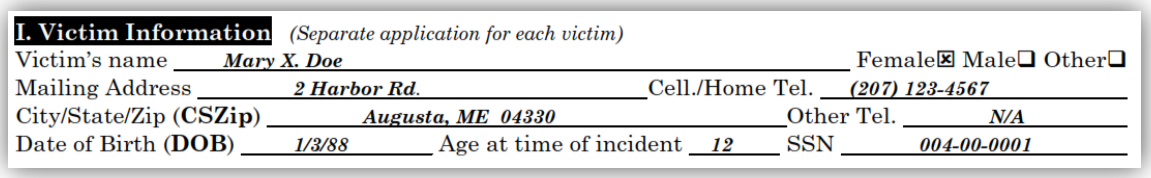
IMPORTANT

PLEASE TAKE A FEW MINUTES TO READ OVER THE ENTIRE APPLICATION BEFORE YOU BEGIN FILLING IN THE INFORMATION REQUIRED IN EACH SECTION.

A decision on your application may take as little as **1 month** or as long as **6 months**, depending on how thoroughly you complete the application and how quickly we can verify your claim from the information you provide. Please call us at 1-800-903-7882 if you have any problems filling out your application form or call the Prosecutor's Office where the criminal case is being handled and ask to speak with your **Victim Witness Advocate**.

I. Victim Information: In this section of the application, provide information about the child or adult who is the primary crime victim.

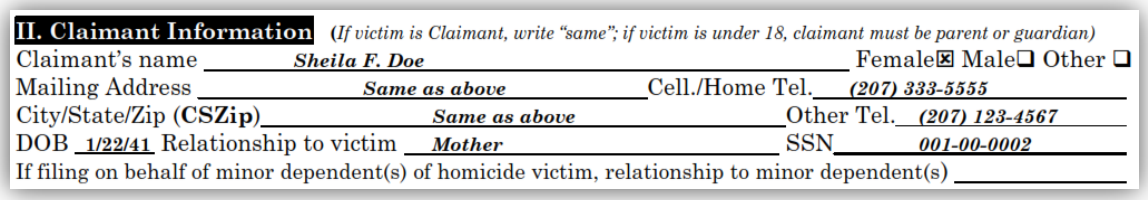
NOTE: SSN is not required but helps us process your case more quickly. Medical providers usually require SSN's to release information.



I. Victim Information *(Separate application for each victim)*
Victim's name ***Mary X. Doe*** Female☒ Male☐ Other☐
Mailing Address ***2 Harbor Rd.*** Cell./Home Tel. ***(207) 123-4567***
City/State/Zip (**CSZip**) ***Augusta, ME 04330*** Other Tel. ***N/A***
Date of Birth (**DOB**) ***1/3/88*** Age at time of incident ***12*** SSN ***004-00-0001***

II. Claimant Information: For adults, the victim will be the claimant. A parent or guardian will be the claimant for a child. In the case of a homicide, a family member usually will be the claimant.

Note: If you move or obtain a **different telephone number**, you must call us with your new address or telephone number immediately. **The Post Office will not forward State checks.**



II. Claimant Information *(If victim is Claimant, write "same"; if victim is under 18, claimant must be parent or guardian)*
Claimant's name ***Sheila F. Doe*** Female☒ Male☐ Other ☐
Mailing Address ***Same as above*** Cell./Home Tel. ***(207) 333-5555***
City/State/Zip (**CSZip**) ***Same as above*** Other Tel. ***(207) 123-4567***
DOB ***1/22/41*** Relationship to victim ***Mother*** SSN ***001-00-0002***
If filing on behalf of minor dependent(s) of homicide victim, relationship to minor dependent(s)

III. Crime Information: Please contact the Prosecutor's Office where the criminal case is being handled and ask to speak with your **Victim Witness Advocate** if you have any issues completing this section!

We must obtain reports from all law enforcement agencies involved in the crime you have reported. Please use full names of individuals, police department, investigating officer and victim advocate to help us process your claim. If at all possible, please provide specific dates for date of crime and date reported. Law enforcement agencies use these dates to locate their reports for each specific crime. (If the crime was NOT reported within 5 days, or if the application was NOT filed within 3 years, please explain why in an attached statement unless the victim is a minor.)

III. Crime Information *(Type of **violent** crime; your **Victim Advocate** can assist you with details)*

☒ assault ❑ child sexual abuse ❑ drunk driving ❑ homicide
❑ sexual assault ❑ terrorizing/threatening ❑ sex trafficking ❑ other _____
Exact location/municipality of crime ***483 Harbor Road*** CSZip ***Augusta, ME 04330***
Date of crime ***1/31/01*** Date crime ended ***2/1/01*** Date crime discovered ***2/1/01*** Date crime reported ***2/1/01***
***Adult victims attach an explanation of reason for delay if crime NOT reported within 5 days, or if application NOT filed within 3 years.**
Name of Police Department ***Augusta Police Dept.*** Investigating Officer ***Robert B. Robin***
Name(s) of person(s) who committed crime ***Clyde Z. Doe*** DOB(s) ***2/3/1940***
Relationship to victim (e.g. father, boyfriend, spouse, stranger, etc.) ***Father***
Who referred you? ☒ Police/Sheriff ❑ District Attorney ❑ Media ❑ Hospital/Dr. ❑ Other _____
❑ Victim Advocate (name) _____ ❑ Tel. _____
Briefly describe the crime and injuries ***Victim was assaulted by her father. He broke her teeth. She went to the hospital and an oral surgeon.***

IV. Expenses: Check box(es) for services you are requesting. Without information about your expenses, we cannot help you. If you or a family member may need mental health counselling in the future but do not need it now, check the mental health box and write "later" next to the line. ***ALWAYS PROVIDE*: All information requested to identify victims and family members who may need counselling. List full names, agency names, office addresses and telephone numbers for all medical, mental health, and funeral service providers as well as the type of provider** (e.g. dentist, counsellor, hospital, X-rays.) Please state which family member is seeing which counsellor and whether any counsellor is seeing the family as a group. Please make clear which family members have insurance, MaineCare, or any other source of partial coverage for their counselling expenses.

Use an additional sheet of paper if you need more room.

IV. Expenses *(Check types of expenses caused by the crime for which you seek compensation)*

☒ medical services* ❑ caregiver assistance ❑ locks repair/replacement*
❑ medical supplies/pharmacy* ❑ lost wages (for victim only) ☒ counselling for victim*
☒ dental services* ❑ loss of financial support/other expenses* (in **homicide cases only**) ☒ counselling for family members* (1) who witnessed crime; or (2) in homicides; or (3) in sexual assault cases or catastrophic injury
❑ funeral/burial/monument*
Name & Address of Funeral Home _____ _____
❑ crime scene cleaning*
***Attach copies of bills and/or receipts** (or send as they become available)

*Complete FULLY for **family or household members** of victim applying for **counselling benefits**:*

Name	Address/CSZip	DOB	Relat. to victim	Relat. to claimant
Sheila F. Doe	*same as above*	*1/22/1941*	*mother*	*self*
Zack P. Doe	*19 Smith Lane, Augusta, 04330*	*4/18/1980*	*brother*	*son*

*Complete FULLY for **medical service providers** (please list type of service, e.g.: hospital, doctor, mental health):*

Name of Provider	Agency/Office Name	Address/CSZip/Tel.		Service
	Northbound Hospital	*6 North St., Augusta*	*626-9999*	*Hospital ER*
Dr. Jack Jackson,	*Oral Surgery Center,*	*2 West St., Augusta*	*623-1111*	*Oral surgeon*
Steven Feste	*Weston St. Dental Assoc*	*11 Weston St., Augusta*	*622-9975*	*Dentist*

V. Lost Income: Lost income is available **for victims** who miss work due to crime related injuries and **for caregivers**, to a **limited extent,** who miss work due to a dependent's disability. You must provide the name, address and telephone number of your employer. State the dates for which you missed work due to you or your dependent's crime-related injuries. Submit two wage stubs showing gross and net wages for two weeks just prior to injury. If you are self-employed or do not have wage stubs, submit copies of your federal tax returns for the last two years.

We need to document your **work disability** with a doctor's statement; please provide the name, address, and telephone number of your doctor who can certify that you were unable to work. **NOTE:** An emergency room provider should **not** complete the disability statement.

(Complete the Employer section for the individual seeking lost wages or caregiver assistance.

V. Lost Income ***Attach 2 recent paystubs. If self- employed, attach your last two years of Federal Income Tax returns)***

Employer ***Acme Sewing*** Contact person ***John Acme***

Address/CSZip/Tel. ***14 Elegant Drive, Bangor, ME 04401 (207) 555-1234***

Dates absent from work due to crime-related injuries **From** ***1/1/2002*** **To** ***1/13/2002***

Treating physician name for disability statement ***John Doe, MD, Waterville Family Practice***

Treating Physician's Address/CSZip/Tel. ***12 Exit Street, Waterville, ME 04901, 872-1212***

VI. Homicide Victim Dependents: Cash assistance may be available for **dependents of homicide victims.** If you are requesting support for dependents of a homicide victim, please provide a copy of any social security award letter, monthly pension and/or annuity benefits. Please be specific as to the amount(s) the deceased person was receiving and what amounts the surviving spouse and/or children are receiving. Please provide copies of the deceased's federal tax returns for the last two years if the dependents are listed on them.

VI. Homicide Victim Dependents *(Complete **ONLY** if requesting financial support for dependent(s) of a homicide victim)*

Name of dependent	DOB	SSN	Relat. to Victim

(Attach last two years of victim's Federal Income Tax returns and Social Security benefit award letter for each dependent)

VII. Current Sources of Financial Assistance: If you have any type of insurance, you **MUST** indicate what type. Check the boxes and give the details requested. Check "NONE" if you have no insurance. If you have medical insurance or receive Medicaid (such as MaineCare or CubCare) or Medicare, it is your responsibility to instruct all providers to bill that source first. Please send in copies of any Medicaid-related eligibility letters (such as MaineCare, CubCare or QMB) and insurance explanation-of-benefit forms; they help us to compute the amounts of awards.

Please contact us **IMMEDIATELY** if you or any of the family or household members listed on your application apply for any other benefits. We might have to check back with your hospital, attorney, mental health provider or some other individual or agency if you are found eligible for any retroactive **OR** ongoing benefits, such as MaineCare, Workers Compensation or Social Security Disability. **Please note that in most circumstances, Victims' Compensation does not delay the processing of your claim while you are waiting for a decision on any other potential benefits!**

Also, if you may qualify for Charity Care at the hospital, ask for and complete an application for Charity Care. **NOTE:** If any of your hospital bills are **over $5,000.00** and you do not have insurance, you will be **required** to apply for Charity Care before we can consider that bill in order to stretch your funds as far as possible.

VII. Current Sources of Financial Assistance *(Check all potential sources of full or partial payment of expenses)*

❑ MaineCare/Medicaid	☒ health insurance	❑ disability benefits	❑ Workers Compensation
❑ Funeral insurance	❑ SSI or TANF	❑ Medicare and/or QMB	❑ Town or City Assistance
❑ Automobile insurance	❑ SSDI	❑ other (please specify)	❑ NONE

Names and addresses of applicable insurance companies Acme Insurance, 121 Corporate Drive, Raleigh, NC 27601 MaineCare or Policy # XV236794-3

If you have a civil attorney as a result of the crime, or if you hire a civil attorney in the future, you must provide the name and address of your attorney.

Have you filed or do you intend to file a **civil lawsuit**? ❑ yes ☒ no ❑ not sure
If yes, Attorney's name _____
Law Firm's Address/CSZip/Tel._____

VIII. Optional Information on Victim: This information is helpful for Federal reporting, as well as informing Victims' Compensation if you would like the opportunity to communicate through an interpreter, but is not mandatory.

VIII. Optional Information on Victim *(For statistical purposes only)*
✓ **Age at time of crime:** ☒ 0 - 12 ❑ 13 - 17 ❑ 18 - 24 ❑ 25 - 59 ❑ 60 +

✓ **Race:** ❑ White Non-Latino/Caucasian ❑ Native Hawaiian and Other Pacific Islander
❑ Black/African American ❑ American-Indian/Alaskan-Native ❑ Asian
❑ Hispanic or Latino ☒ Multiple Races ❑ Other Race: _____

✓ **English-speaking?** ☒ yes ❑ no **Primary Language** _____
✓ **Did crime involve bullying or elder abuse?** ❑ yes ☒ no
✓ **Disabled prior to crime?** ❑ yes ☒no

INFORMATION RELEASE and AGREEMENT AND WARNING

Please read these sections carefully.

The **Release** allows us to obtain information and records from **all** sources to decide your claim.

The **Agreement and Warning** states that you have to tell the truth in the application and when you speak to us, that you need to keep us informed if you apply for or receive other benefits, and that you agree to pay us back, or have your civil attorney pay us back, if you recover money in a civil settlement or from insurance that covered the same losses already paid for by Victims' Compensation. Also, if you receive restitution money in the criminal case after you have received Victims' Compensation benefits, please call us.

If you have no questions, sign and date the Release **and** sign and date the Agreement and Warning.
Yes, **sign in two places**. We are unable to process your claim until you have done so.

If you have **any questions** after reading these instructions, please call Victims' Compensation at **1-800-903-7882** or call the Prosecutor's Office where the criminal case is being handled and ask to speak with your **Victim Witness Advocate**.

An incomplete application will delay your claim.

STOP

Please review your application one last time to make sure all parts are filled in or signed and that you have attached required statements and bills.

We sincerely hope that financial assistance from the Victims' Compensation Program will be able to provide you with some relief and support during this stressful time.

Should you have questions or wonder about the status of your application, please feel free to contact Victims' Compensation at anytime to inquire about your claim.